

Effects of the Mindful Self-Compassion programme on clinical and health psychology trainees' well-being: A pilot study

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Abstract

Background: Clinical and health psychologists are often exposed to occupational hazards, such as burnout and compassion fatigue, which originate from emotional demands at work. Mindful Self-Compassion (MSC) training has been demonstrated to be useful in increasing well-being and enhancing mental health. Although the use of the MSC programme in educational contexts has been suggested, an evaluation of its efficacy as a method to improve the competencies of trainees in clinical psychology has yet to be performed.

Methods: Our study used a sample of 61 adults (88.5% women) attending postgraduate courses in clinical and health psychology who participated in an 8-week MSC programme. Their levels of self-compassion, mindfulness, well-being, anxiety and depression symptoms were assessed before and after the intervention. Based on the participants' adherence to the MSC programme, two groups were created, that is, high ($n = 30$) versus low ($n = 31$) adherence.

Results: The participants in the high-adherence group benefitted from the MSC programme because they increased their self-compassion, mindfulness and psychological well-being scores. The extent to which the participants reported to have been committed to the MSC practice was associated with changes in self-compassion, mindfulness and psychological well-being. Furthermore, the changes in self-compassion were significantly correlated with changes in mindfulness and psychological well-being.

Conclusion: The MSC programme offers a promising way to develop professional competencies and enhance the well-being of trainees in clinical psychology.

KEYWORDS

mental health professionals, mindfulness, psychology training, self-compassion, well-being

1 | INTRODUCTION

Mental health professionals are exposed to numerous psychosocial hazards, which may result in severe

outcomes, such as compassion fatigue, burnout syndrome, depression and anxiety-related problems, especially in the early stages of their careers (Lim, Kim, Kim, Yang, & Lee, 2010; Volpe et al., 2014). A growing body of

literature has identified strategies to cope with these risks and demonstrates that mindfulness and compassion are protective factors against the negative outcomes of emotionally demanding tasks in mental health-care contexts (Beaumont, Durkin, Hollins-Martin, & Carson, 2016; Di Benedetto & Swadling, 2014; Ray, Wong, White, & Heaslip, 2013; Thompson, Amatea, & Thompson, 2014). As previous research indicates, the cultivation of compassion may produce positive outcomes for physiological functioning, psychological health, emotion regulation, and social relationships (Kirby, 2017; Matos et al., 2017).

1.1 | Compassion and self-compassion in clinical and health psychology practice

With the development of compassion-focused research and literature, many more psychologists are increasingly interested in the benefits of these approaches, especially in the field of psychotherapy (Kirby, 2017; Kirby & Gilbert, 2017; Kirby, Tellegen, & Steindl, 2017). Compassion is an important element in effective psychotherapy. As Finlay-Jones (2017) has pointed out, for clients, compassion is a target of effective treatment as well as a key process; for therapists, compassion is important to enhance their personal and professional wellbeing. A group of therapists viewed as particularly compassionate by peers conceptualised compassion as being connected to the clients' suffering, being able to understand and identify with this suffering, and being able to use this understanding to promote helpful changes in the client's life (Vivino, Thompson, Hill, & Ladany, 2009). Cognitive, emotional, motivational, and interpersonal elements are intertwined in the construct of compassion. A recent review of conceptualisations has identified the following five core dimensions of compassion: acknowledging that suffering is present; understanding that suffering is universal and characterises human experience; being moved by and emotionally connected to the suffering person; accepting possible uncomfortable feelings; and having a disposition to alleviate suffering (Gu, Cavanagh, Baer, & Strauss, 2017; Strauss et al., 2016). Likewise, Gilbert (2010) considers compassion to include sensitivity to other people's emotions and needs, concern for another person's suffering, empathy, the motivation to care for other people, tolerance of distress, and a non-judgemental attitude.

The cultivation of self-compassion may help clinical and health psychologists to adopt a compassionate approach in the course of psychotherapeutic interventions. Therapists who can connect with their own prior experience of suffering may more naturally acknowledge and understand the client's suffering (Vivino et al., 2009).

Key points

1. This is the first study to evaluate the Mindful Self-Compassion programme as a method to improve self-compassion and mindfulness among trainees in clinical and health psychology. The results support the usefulness of a compassion-based intervention to promote the well-being of psychology trainees.
2. The Mindful Self-Compassion programme can be used to enhance the therapists' skills, which could protect them from compassion fatigue and similar occupational hazards.
3. Training clinical and health psychologists in mindfulness and self-compassion could help them to treat clients with compassion, dignity and respect as fundamental aspects of care.

In addition, training in self-compassion and compassion towards other people has been suggested to improve care and may be useful to promote job satisfaction in health-care workers (Scarlet, Altmeyer, Knier, & Harpin, 2017).

According to Neff (2003, 2016), self-compassion entails the three components of self-kindness, mindfulness and common humanity. Self-kindness is characterised as being benevolent, caring, and non-judgemental towards oneself rather than engaging in excessive self-criticism. In Neff's definition of self-compassion, the mindfulness component is referred to as being fully aware of and open to one's painful or disturbing feelings instead of over-identifying with them. Concerning the common humanity component, self-compassion entails a new perspective on pain and suffering. Suffering and painful experiences are part of our common human condition. In this regard, self-compassion entails a feeling of being connected to other suffering beings rather than feeling isolated and separated (Neff, 2003, 2016).

From this compassionate perspective, individuals can be trained to encounter disturbing experiences with openness, acceptance, kindness, empathy, equanimity and patience (Feldman & Kuyken, 2011), which has been associated with positive psychological outcomes. Barnard and Curry (2011), for instance, collected evidence from previous literature showing that self-compassion is related to positive affect, well-being, life satisfaction and happiness. A meta-analysis focused on this topic revealed that self-compassion and well-being are strongly related (Zessin, Dickhäuser, & Garbade, 2015). Further, self-compassion has been negatively associated with negative affect, anxiety, depression, and mental health symptoms

(Barnard & Curry, 2011; MacBeth & Gumley, 2012). Finlay-Jones, Rees, and Kane (2015) have found that self-compassion is negatively associated with emotion regulation difficulties and stress among psychologists.

1.2 | The mindfulness-based approach to cultivating compassion and self-compassion skills

Mindfulness is defined as the capacity to focus and maintain attention on the immediate present experience and approach the present with an orientation characterised by openness, curiosity and acceptance (Bishop et al., 2004). Compassion requires a skilled capacity to observe one's own thoughts and feelings by adopting a non-judgemental attitude (Gilbert & Tirsch, 2009). Similarly, being mindfully aware of personal suffering is a precondition to cultivate self-compassion (Neff & Germer, 2013). In this regard, mindfulness has been suggested to prompt self-compassionate attitudes that could foster happiness (Hollis-Walker & Colosimo, 2011).

The results from empirical research have supported a connection between mindfulness and compassion/self-compassion. To a great extent, mindfulness and self-compassion overlap. For instance, studies by Baer, Lykins, and Peters (2012) and by Hollis-Walker and Colosimo (2011) have reported Pearson's $r = .69$, which indicates almost 48% of the variance is shared between these variables. However, other research has demonstrated that self-compassion may be a more robust predictor of psychological symptom severity and quality of life than mindfulness (Van Dam, Sheppard, Forsyth, & Earleywine, 2011).

Mindfulness-based interventions have been found to increase self-compassion and reduce negative emotions such as shame in people's suffering and symptoms of anxiety and depression (Proeve, Anton, & Kenny, 2018). Similarly, a study found increases in empathy and self-compassion after participating in a mindfulness training programme (Birnie, Speca, & Carlson, 2010). From the perspective of neurobiology, mindfulness meditation appears to be associated with changes in brain activity in the neurological areas related to caring, compassion, and kindness (Tirsch, 2010).

Mindfulness is a fundamental component of most trainings that aim to cultivate compassionate attitudes towards other people and the self. Various interventions focused on training compassion and/or self-compassion through mindfulness-based practices have been shown to produce changes in a wide range of symptoms and well-being-related outcomes (Kirby, 2017; Kirby, Tellegen, & Steindl, 2015). For instance, the Mindful Self-Compassion

(MSC) programme is intended for use in clinical and non-clinical settings (Neff & Germer, 2013). It consists of an 8-week protocol that comprises a variety of mindfulness-based meditation practices (e.g., loving-kindness, affectionate breathing) learned in 2.5-hr instructional, experiential sessions and is complemented with weekly homework exercises. Previous research has supported the effectiveness of both the MSC programme and its adapted versions. Randomised controlled trials have shown that mindful self-compassion trainings are useful in reducing symptoms of depression, anxiety, stress, emotional avoidance and cognitive rumination (Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2016; Neff & Germer, 2013; Smeets, Neff, Alberts, & Peters, 2014). In addition, self-compassion meditation has been shown to be useful to treat specific problems such as body dissatisfaction (Albertson, Neff, & Dill-Shackleford, 2015) and psychological and metabolic symptoms associated with diabetes (Friis, Johnson, Cutfield, & Consedine, 2016). The results of uncontrolled pilot studies and clinical case-reports have also suggested the benefits of the MSC programme (Finlay-Jones, Xie, Huang, Ma, & Guo, 2017; Germer & Neff, 2013).

1.3 | Mindfulness and compassion-related training in the context of the Personal Practice model

Personal practice (PP) has emerged as a relevant issue in therapists' training. According to Bennett-Levy and Finlay-Jones (2018), PP refers to therapists' engagement in psychological interventions and techniques focused on personal development, which may also be a means to enhance professional skills. PP comprises a variety of trainings, for example, meditation/mindfulness-based programmes, loving-kindness and compassion programmes, and therapy self-practice/self-reflection programmes. Participation in such practices may promote personal development and well-being, self-awareness, and reflective skills and may impact interpersonal attitudes, beliefs and skills. Beyond such impacts to the "personal self," reflecting on the implications of PP may also have an impact on the "therapist self" and contribute to enhancing therapists' conceptual and technical skills (Bennett-Levy & Finlay-Jones, 2018). A recent systematic review concluded that mindfulness-based interventions are generally associated with enhanced well-being among a variety of health-care professionals (Lomas, Medina, Ivtzan, Rupperecht, & Eiroa-Orosa, 2018). Mindfulness-based programmes offered to health professionals to promote professional development have demonstrated efficacy in reducing stress-related symptoms and improving compassion not only in mental

health professionals (Raab, Sogge, Parker, & Flament, 2015) but also in oncology nurses (Duarte & Pinto-Gouveia, 2016) and surgeons (Fernando, Consedine, & Hill, 2014). Medical students can also benefit from participating in mindfulness trainings. Increased self-compassion and reduced perceived stress have been reported as positive outcomes (Erogul, Singer, McIntyre, & Stefanov, 2014). In addition, mindfulness interventions could also help medical students respond to difficult clients with compassion (Fernando, Skinner, & Consedine, 2017).

Concerning clinical psychologists and psychotherapists in training, mindfulness-based interventions may be useful to promote a variety of positive outcomes. For instance, enhanced compassion and empathy, self-compassion, awareness, emotion regulation, and mental health have usually been reported after participation in mindfulness-based trainings (Dorian & Killebrew, 2014; Hemanth & Fisher, 2015; Hopkins & Proeve, 2013; Shapiro, Brown, & Biegel, 2007). In addition, participation in mindfulness-based interventions may increase the understanding of what it is like to be a client among clinical psychology trainees and may have positive impacts on their job performance (Grepmaier, Mitterlehner, Loew, & Nickel, 2007; Rimes & Wingrove, 2011).

Similarly, the practice of loving-kindness meditation could be an effective strategy for coping with the emotional demands in health professions, and it has been suggested as a method of self-care for clinicians and therapists in training (Boellinghaus, Jones, & Hutton, 2013, 2014). Despite the evidence that supports that loving-kindness meditation may improve mood and boost therapists' empathy and personal resources (Bibeau, Dionne, & Leblanc, 2016; Cohn & Fredrickson, 2010), its use among mental health professionals is still scarce and often appears in the context of multi-component training programmes, which makes it difficult to disentangle its particular effects (Boellinghaus et al., 2014; Rao & Kemper, 2017; Shapiro, Astin, Bishop, & Cordova, 2005). In this regard, more empirical evidence to guide the implementation of PP programmes is needed, especially regarding compassion-based interventions (Bennett-Levy & Finlay-Jones, 2018; Freeston, Thwaites, & Bennett-Levy, 2019).

1.4 | Purpose of the current study

There is a need for training in self-care for clinical psychology students, as Pakenham (2017) suggests. Moreover, the PP models suggest that self-experiential learning may be helpful for therapists both at the personal and professional development levels. However, as stated before, up-to-date research on this topic is scarce.

The MSC training programme aims to promote the cultivation of self-compassion, mindfulness and value-oriented behaviour. According to Neff and Germer (2013), teaching the MSC programme to clinicians and health-care professionals is a promising research direction, as this training could help these individuals cope with the challenges of life, ameliorate suffering and enhance well-being. However, to date, no studies have tested the effectiveness of the MSC programme as applied to the emotional training of future mental health professionals.

The present study builds on Neff and Germer's abovementioned suggestion and aims to test the effects of the MSC programme delivered to clinical and health psychology students as part of their postgraduate education. Drawing from previous research, two hypotheses will be tested.

Hypothesis 1 After the training, participants in the MSC programme will increase their levels of self-compassion (H1.1) and mindfulness (H1.2).

Hypothesis 2 The MSC training will produce beneficial psychological outcomes. Psychologists will improve their levels of well-being (H2.1) and mental health (H2.2) after participation in the MSC programme.

These hypotheses are consistent with the PP model. As Bennett-Levy and Finlay-Jones (2018) have proposed, PP will have a primary and direct impact on the personal self, with outcomes on personal development and well-being, self-awareness, and interpersonal beliefs/attitudes/skills. In addition, therapists engaged in PP are expected to enhance their reflective skills. The expected improvements in mindfulness, self-compassion, and well-being after participation in the MSC programme are congruent with the expected improvements established in the PP model.

2 | METHODS

2.1 | Participants and procedure

Psychologists attending postgraduate courses in clinical and health psychology were trained in the MSC programme, and possible changes in self-compassion, mindfulness and psychological well-being were evaluated.

The sample comprised 61 adults (88.5% female) aged 21–61 years old, with a mean age of 25.6 years ($SD = 7.19$). The sample was considerably homogeneous in terms of socio-demographic characteristics. All participants were middle-class Spanish nationals who were unmarried and

without children. They were postgraduate psychologists with less than 1 year of professional experience, were enrolled in a Master's degree programme in Clinical and Health Psychology and had no previous experience with compassion-focused interventions and/or meditation practices. Participation in the MSC training was voluntary, and the students did not receive any material or academic compensation. Informed consent was obtained from all individual participants, and all procedures were conducted according to the ethical approval of the Research Ethics Committee of Pontifical University of Salamanca.

Following Neff and Germer (2013), the MSC training was delivered in an 8-week, in-person, group-session format. Each session lasted for 2.5 hr. The contents of weekly sessions included an introduction to self-compassion (Session 1), practising mindfulness (Session 2), practising meditation (Session 3), practising compassion (Session 4), clarifying personal values (Session 5), managing difficult emotions (Session 6), transforming interpersonal relationships (Session 7), and coping with life issues (Session 8). Training sessions are based on experiential learning, and the contents are addressed through the practice of self-compassion and reflective exercises. In MSC terms, "formal practices" refer to meditation exercises, for example, loving-kindness meditation and affectionate breathing, intended to be performed regularly at moments set aside specifically for meditation purposes. "Informal practices" are intended to be frequently conducted in the course of daily life and include exercises such as self-compassionate letter writing, putting one hand on the body in a warm, caring, and gentle way, savouring food, gratitude exercises, going for a walk while maintaining a mindful and compassionate attitude, and so on (Germer & Neff, 2013; Neff & Germer, 2018). In addition to attending the training sessions, the participants were also asked to complete weekly tasks, which usually consisted of performing meditation exercises and the informal practices previously learned at each session. Examples of MSC exercises can be found in a recently published workbook written by the programme's developers (Neff & Germer, 2018). A detailed description of the MSC protocol is also available (Germer & Neff, 2019). All group sessions were conducted by a clinical psychologist with previous specialised training in the MSC protocol (Certified Trained Teacher, Center for MSC). This clinical psychologist was assisted by a co-therapist who helped with basic group management tasks.

2.2 | Study design

To evaluate the efficacy of the MSC training, a quasi-experimental design was used, with pre- and post-

intervention measures and no control group. Due to logistical issues, 18 participants could not complete the positive well-being measure, and 18 individuals could not complete the mindfulness questionnaire; therefore, data from only 43 participants were available for these variables.

2.3 | Instruments

The Self-Compassion Scale (SCS) includes 26 items that aim to assess an individual's disposition to self-kindness rather than self-criticism, mindful awareness rather than over-identification with distressing inner experiences, and perceptions of shared humanity rather than isolation (Neff, 2003; Spanish adaptation by Garcia-Campayo et al., 2014). An example item is "I'm kind to myself when I'm experiencing suffering." Higher total scores indicate higher levels of self-compassion. The Cronbach's alpha indicated good internal reliability (pre-test: $\alpha = .83$; post-test: $\alpha = .89$).

The Five Facets of Mindfulness Questionnaire (FFMQ) is a 39-item instrument designed to evaluate the respondents' general disposition towards being mindful in daily life (Baer et al., 2006; Spanish version by Cebolla et al., 2012). This scale assesses the respondents' ability to act with awareness, describe their feelings, and observe their inner experiences while maintaining a non-reactive and non-judgemental attitude. An example item is "When I do things, my mind wanders off and I'm easily distracted" (reversed). Higher total scores are indicative of a higher tendency to be mindful in daily life. The Cronbach's alpha indicated good internal reliability (pre-test: $\alpha = .85$; post-test: $\alpha = .91$).

The Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996; Spanish adaptation by Sanz & Vázquez, 2011) consists of 21 questions that assess the intensity of depression-related items, with higher scores representing a higher severity of symptoms. An example item is "Sadness: 0. I do not feel sad; 1. I feel sad much of the time; 2. I am sad all the time; 3. I am so sad or unhappy that I can't stand it." The Cronbach's alpha presented values indicative of good internal reliability (pre-test: $\alpha = .92$; post-test: $\alpha = .95$).

The Spanish adaptation of the State Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970, 1982) was used to measure the current level of anxiety experienced by the participants. This instrument comprises 20 items that pertain to an anxiety affect, with higher scores indicating greater anxiety. An example item is "I am tense." The Cronbach's alpha was $\alpha = .91$ at pre-test and post-test for this scale.

The Psychological Well-Being Scales (Ryff, 1989a, 1989b; Spanish adaptation by Triadó, Villar, Osuna, &

Solé, 2005; Triadó, Villar, Solé, & Celdrán, 2007) use 54 items to measure the respondents' level of subjective well-being and encompass aspects related to autonomy, environmental mastery, personal growth, positive relationships with other people, purpose in life, and self-acceptance. An example item is "When I look at the story of my life, I am pleased with how things have turned out." Higher total scores represent greater levels of psychological well-being. The Cronbach's alpha was $\alpha = .94$ at both pre-test and post-test.

A single-item measure ("Could you please indicate, in terms of percentage, your degree of adherence to the training programme?") was included in the post-test questionnaire to evaluate the participants' compliance with the MSC protocol. They were informed that their responses should reflect a global self-evaluation of the extent to which they had attended the programme's sessions, been actively engaged in the formal and informal practices, and undertaken homework tasks.

2.4 | Data analysis

Descriptive statistics were calculated for the study's variables. To assess the efficacy of the intervention, the total sample was divided into two groups based on the participants' adherence to the MSC training by using the sample's median as the splitting criterion. Therefore, high-adherence ($n = 30$) and low-adherence ($n = 31$) groups were created. In addition, the median criterion incidentally represented adherence to 50% of the training, that is, high- and low-adherence participants completed more and less than 50% of the MSC programme, respectively.

Repeated-measures mixed analysis of variances (ANOVAs) were conducted to analyse the possible differences in mindfulness, self-compassion, anxiety, depression, psychological well-being and life satisfaction between the

high- and low-adherence groups over time (pre-/post-intervention). The data requirements for conducting mixed ANOVA analyses were met. A Bonferroni adjustment was used for pairwise comparisons. In addition, standardised residual change scores were calculated. This method estimates the change in variables by initially regressing the post-test scores on the pre-test scores and then subtracting the predicted post-test scores from the observed post-test scores. The change scores were reasonably adjusted to normality, except the BDI change scores. Independent-sample t tests were used to identify the between-group (high vs. low adherence) differences in the change scores. The requirement of homogeneity of variances was met. Pearson's r correlations was used to analyse the relationships among the change scores, which allows the identification of whether the change in a variable is associated with changes in other variables. All analyses were conducted by using SPSS 16.0 statistical software (IBM, Armonk, NY).

3 | RESULTS

Overall, our sample presented moderate values of self-compassion, mindfulness and psychological well-being. The scores for depression and state anxiety indicated the absence of psychological symptoms (Table 1).

3.1 | MSC training outcomes

The high-adherence group reported an average level of participation in the programme of 71.83% ($SD = 20.78$), whereas the low-adherence participants, on average, completed 19.67% ($SD = 16.37$) of the training. The between-group differences in participation were statistically significant ($t_{59} = -10.91$; $p < .001$).

TABLE 1 Descriptive statistics (means and standard deviations) by high-/low-adherence group

| | Total sample | | | | High-adherence group | | | | Low-adherence group | | | |
|--------------------------------------|--------------|-----------|----------|-----------|----------------------|-----------|----------|-----------|---------------------|-----------|----------|-----------|
| | Pre | | Post | | Pre | | Post | | Pre | | Post | |
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> |
| Self-compassion (range 1–5) | 3.14 | 0.42 | 3.33 | 0.48 | 3.11 | 0.42 | 3.43 | 0.51 | 3.17 | 0.42 | 3.23 | 0.44 |
| Mindfulness (range 1–5) | 2.99 | 0.43 | 3.21 | 0.46 | 3.03 | 0.46 | 3.36 | 0.53 | 2.96 | 0.41 | 3.10 | 0.37 |
| Depression (range 0–63) | 5.08 | 6.58 | 4.26 | 7.29 | 5.23 | 8.00 | 3.07 | 3.17 | 4.94 | 4.96 | 5.42 | 9.68 |
| State anxiety (range 0–60) | 24.84 | 15.33 | 24.95 | 15.44 | 21.97 | 14.99 | 22.00 | 15.60 | 28.20 | 15.30 | 27.90 | 14.95 |
| Psychological well-being (range 1–6) | 3.95 | 0.61 | 3.98 | 0.62 | 4.05 | 0.66 | 4.22 | 0.64 | 3.87 | 0.55 | 3.76 | 0.52 |

Notes: Self-compassion, $n = 61$ (31 low-adherence, 30 high-adherence); mindfulness, $n = 43$ (24 low-adherence, 19 high-adherence); depression, $n = 61$ (31 low-adherence, 30 high-adherence); state anxiety, $n = 60$ (30 low-adherence, 30 high-adherence); psychological well-being, $n = 43$ (22 low-adherence, 21 high-adherence).

The repeated-measures mixed ANOVA revealed a statistically significant interaction between group and time for self-compassion ($F_{1,59} = 7.59$; $p < .01$; $\eta^2 = .114$). As presented in Figure 1, the mean self-compassion scores for the participants in the low-adherence group remained stable over time ($F_{1,59} = 0.80$; $p > .05$; $\eta^2 = .013$), whereas those for the participants in the high-adherence group significantly increased from pre- to post-intervention ($F_{1,59} = 22.53$; $p < .001$; $\eta^2 = .276$). This result supports H1.1.

For both the high-adherence group ($F_{1,41} = 21.57$; $p < .001$) and the low-adherence group ($F_{1,41} = 4.97$; $p < .05$), the mindfulness scores significantly increased over time (Figure 2). The interaction between group and time yielded a marginally significant value for mindfulness, as shown by the repeated-measures mixed ANOVA ($F_{1,41} = 3.95$; $p = .05$; $\eta^2 = .088$). The changes from pre- to post-intervention were greater for participants with a higher adherence to the training programme ($\eta^2 = .345$) than for participants with low adherence, who experienced only a slight increase ($\eta^2 = .108$). This result partially supports H1.2.

As presented in Figure 3, subjective well-being slightly decreased from pre-training to post-training in the low-adherence group, although these changes were not statistically significant ($F_{1,41} = 2.15$; $p > .05$; $\eta^2 = .050$). Inversely, the mean scores in psychological well-being significantly increased over time for the high-adherence group ($F_{1,41} = 4.28$; $p < .05$; $\eta^2 = .095$). The

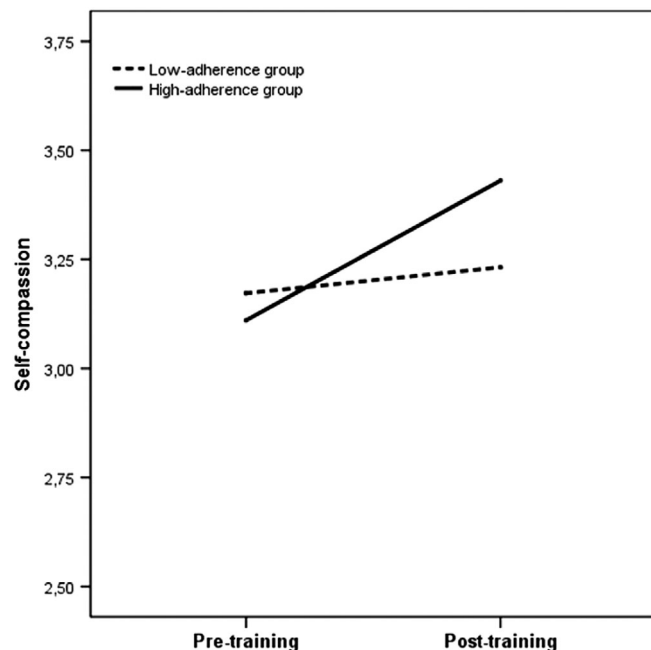


FIGURE 1 Interaction effects between time and the high-/low-adherence group on self-compassion

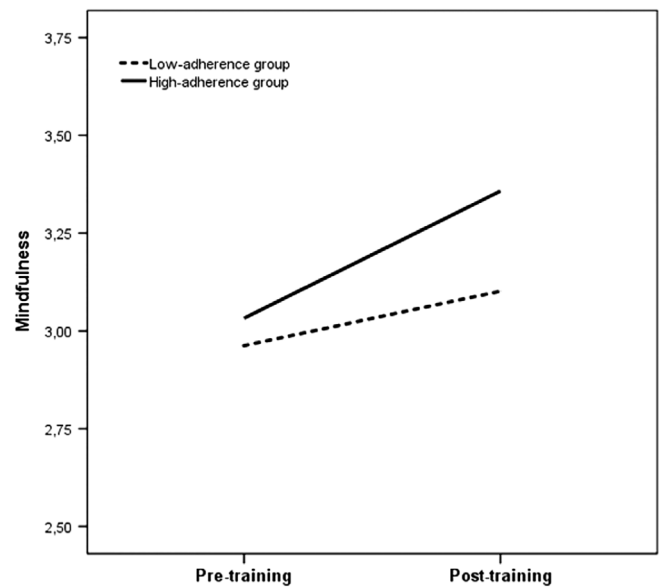


FIGURE 2 Interaction effects between time and the high-/low-adherence group on mindfulness

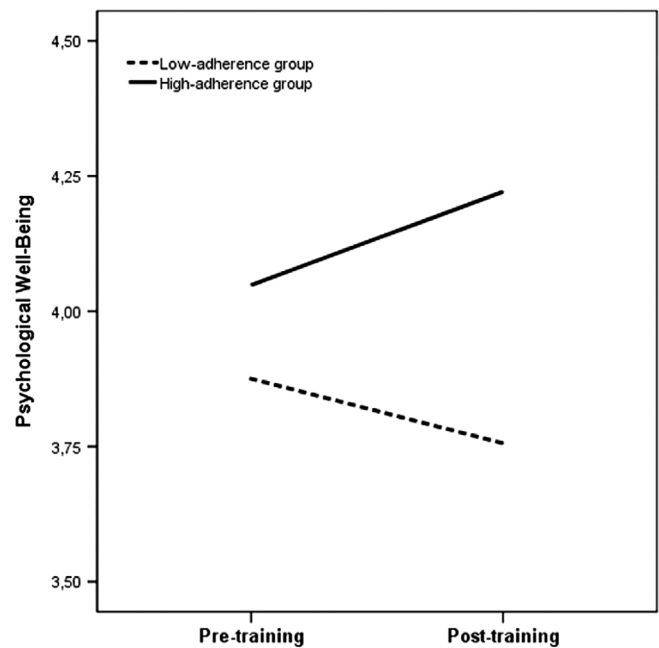


FIGURE 3 Interaction effects between time and the high-/low-adherence group on psychological well-being

repeated-measures mixed ANOVA yielded a significant result for the interaction between group and time ($F_{1,41} = 6.27$; $p < .05$; $\eta^2 = .133$). This result supports H.2.1. No significant interaction effects between the time and adherence groups were found concerning the depression ($F_{1,59} = 1.53$; $p > .05$; $\eta^2 = .025$) and state anxiety ($F_{1,58} = 0.03$; $p > .05$; $\eta^2 = .001$) scores. Hypothesis 2.2 was therefore not supported.

TABLE 2 Mean comparisons for the standardised residual change scores, by high-/low-adherence group

| | High-adherence group | | Low-adherence group | | Independent samples <i>t</i> test | | Cohen's <i>d</i> effect size |
|--------------------------|----------------------|-----------|---------------------|-----------|-----------------------------------|-----------|------------------------------|
| | Mean | <i>SD</i> | Mean | <i>SD</i> | <i>t</i> | <i>df</i> | |
| Self-compassion | 0.33 | 1.06 | -0.32 | 0.82 | -2.69** | 59 | 0.69 |
| Mindfulness | 0.36 | 0.95 | -0.29 | 0.94 | -2.23* | 41 | 0.69 |
| Depression | -0.17 | 0.43 | 0.17 | 1.31 | 1.37 | 59 | -0.35 |
| State anxiety | -0.02 | 1.03 | 0.02 | 0.98 | 0.17 | 58 | -0.04 |
| Psychological well-being | 0.43 | 0.68 | -0.41 | 1.07 | -3.04** | 41 | 0.94 |

Notes: Self-compassion, $n = 61$ (31 low-adherence, 30 high-adherence); mindfulness, $n = 43$ (24 low-adherence, 19 high-adherence); depression, $n = 61$ (31 low-adherence, 30 high-adherence); state anxiety, $n = 60$ (30 low-adherence, 30 high-adherence); psychological well-being $n = 43$ (22 low-adherence, 21 high-adherence).

* $p < .05$.

** $p < .01$.

TABLE 3 Pearson's *r* correlations among programme adherence, change in self-compassion, change in mindfulness, change in psychological symptoms, and change in psychological well-being

| | 1 | 2 | 3 | 4 | 5 |
|--|------------|------------|-----------|-------------|-------------|
| 1. Programme adherence | | | | | |
| 2. Self-compassion change score | .46 (61)** | | | | |
| 3. Mindfulness change score | .39 (43)* | .52 (43)** | | | |
| 4. Depression change score | -.20 (61) | -.27 (61)* | -.14 (43) | | |
| 5. State anxiety change score | -.05 (60) | -.16 (60) | .09 (42) | .47 (60)** | |
| 6. Psychological well-being change score | .43 (43)** | .47 (43)** | -.10 (25) | -.60 (43)** | -.39 (43)** |

Note: In parentheses, n available for the computation of correlation coefficients is reported.

*Correlation is significant at the .05 level (two-tailed).

**Correlation is significant at the .01 level (two-tailed).

3.2 | Analysis of the change scores

The standardised residual change scores significantly differed by group, with high compliers modifying their scores in self-compassion, mindfulness and well-being to a greater extent than low compliers (Table 2). Cohen's *d* denoted that group differences were of a moderate magnitude. The high- and low-adherence groups were not significantly different in terms of the change scores for depression and state anxiety.

Correlation analyses also confirmed that the extent to which trainees had actively participated in the MSC programme was significantly associated with changes in self-compassion, mindfulness, and psychological well-being (Table 3). Higher levels of participation were associated with greater changes in these variables from pre- to post-training. Some changes were interrelated. Higher increases in self-compassion from pre- to post-intervention were significantly connected to increased mindfulness and psychological well-being and to reduced depression symptoms over time. Significant correlations among the changes in scores for anxiety, depression, and subjective well-being were also observed.

4 | DISCUSSION

This research provides preliminary evidence for the usefulness of the MSC programme during clinical and health psychologists' training. In particular, the trainees who completed the programme to a greater extent reported increases in self-compassion, mindfulness, and psychological well-being. In comparison, low-adherence participants maintained their previous levels of self-compassion and well-being and just slightly increased their mindfulness skills. The between-group mean comparisons in the change scores also revealed significant differences between the high- and low-adherence groups. As expected, greater changes in self-compassion, mindfulness and psychological well-being were observed for the high-adherence group than for the low-adherence group. The high-adherence group increased their self-compassion and well-being scores from pre- to post-intervention, whereas the low-adherence group remained statistically stable over time.

A different pattern was found concerning mindfulness. Both the high- and low-adherence participants increased their mindfulness skills, with the participants

in the high-adherence group, as expected, reporting greater improvements. The improvements observed in the mindfulness scores of the low-adherence group may be explained by the fact that mindfulness meditation is an elementary practice in the MSC protocol, is introduced early in the programme's sessions and is used as a basis for other exercises. Therefore, even the low-adherence participants could have learned some basic mindfulness-based techniques. In any case, higher adherence to the programme corresponded to higher increases in mindfulness.

Overall, the changes experienced by the high-adherence group presented medium effect sizes, which indicates that participation in the training programme enhanced mindfulness skills and self-compassionate attitudes, and promoted positive outcomes, that is, subjective well-being. The results are consistent with the findings from a meta-analysis by Kirby et al. (2017), who found that compassion-based interventions generally produced medium effect-size changes in outcome variables such as self-compassion, mindfulness and well-being, among others. Neff and Germer (2013) found changes of a large and moderate magnitude for self-compassion and mindfulness, respectively, following participation in the MSC training, which was assessed through a randomised controlled trial design. The Cohen's d effect size was 1.67 for self-compassion in Neff and Germer's study, whereas our research yielded a Cohen's $d = 0.69$ for this variable. The findings are more similar regarding the magnitude of the between-group differences in mindfulness, with Cohen's $d = 0.69$ in our study and Cohen's $d = 0.60$ in Neff and Germer's research. Moreover, Neff and Germer (2013) reported that Cohen's $d = 0.51$ for the group differences in life satisfaction, whereas Cohen's $d = 0.94$ was found in the current study for the differences concerning the similar variable of psychological well-being. Therefore, our MSC intervention produced group differences compatible with the group differences previously reported for this programme. However, it should be noted that Neff and Germer's results come from a more robust experimental design that included a control wait-list group.

An analysis of the standardised residual change scores provided additional support for the training's efficacy. When the participants complied more with the training, their scores in self-compassion, mindfulness, and psychological well-being increased more remarkably from the pre- to post-measures. Similarly, to Neff and Germer (2013), who reported 24% shared variance between the changes in mindfulness and the changes in self-compassion, we found 27% of shared variance ($r = .52$) between the changes in these variables. This finding provides evidence for the association between mindfulness and self-compassion (Baer et al., 2012;

Hollis-Walker & Colosimo, 2011). Consistent with previous studies (Barnard & Curry, 2011; Zessin et al., 2015), the results showed that changes in self-compassion are strongly associated with changes in psychological well-being. In support of the results reported in a previous meta-analysis (Zessin et al., 2015), we found that $r = .47$ for the association between the changes in self-compassion and the changes in psychological well-being. This finding emphasises that interventions that aim to foster well-being may benefit from a focus on compassion.

The results differed from previous research concerning depression and anxiety measures. The high- and low-adherence groups presented similar scores on these variables. In addition, although MacBeth and Gumley (2012) reported strong correlations between self-compassion and psychological symptoms, such as depression and anxiety, we found rather weak relationships between the changes in self-compassion and the changes in depression and anxiety. These unexpected findings could be accounted for by the characteristics of the sample that participated in this study. Unlike other studies, our study did not focus on a clinical population. Neff and Germer (2013), by using a non-clinical sample, reported strong changes in depression and anxiety among the programme's outcomes. However, the participants in their study presented higher pre-test scores for these symptom-related variables than the participants in our study. In fact, our participants were postgraduate psychologists who reported very low levels of depression and low anxiety scores at the time of the pre-test measurement, which likely made it difficult to reduce their scores to even lower levels.

4.1 | Limitations and future study

The contributions of the current study should be considered in light of its limitations. From a methodological perspective, randomised controlled trials would be highly encouraged (Lomas et al., 2018), especially for emergent approaches such as the MSC training. The present study did not utilise a control group, and randomisation is absent. Despite this limitation, the low-adherence group played a role similar to the role of a control group. The low-adherence participants assessed that, on average, they had complied with less than 20% of the MSC protocol. In addition, their scores remained stable from pre- to post-test measures. Despite this group's increase in their mindfulness scores, such changes presented a small magnitude.

A second limitation comes from the few data available for some analyses. For instance, the correlation

between the mindfulness and well-being change scores yielded an unexpected, although statistically non-significant, result. However, this analysis involved just 25 individuals, and a further inspection revealed that 20 of them had completed 50% or less of the programme, which makes this result difficult to interpret.

Some limitations concerning the available sample should be acknowledged. The postgraduate psychology courses where the training was offered comprised a large proportion of females; therefore, males were underrepresented in the current study. In addition, a potential self-selection bias in adhering to the programme cannot be discounted. Likely, the participants who presented higher adherence to the training may also have had a preexisting positive view of mindfulness. The high compliers may also have higher motivation. For instance, they might also see the training as another tool to use with clients, thereby increasing their adherence to the programme. Moreover, the sample presented scores that indicated low levels of anxiety and depression. Contrarily, as Pakenham (2017) has pointed out, clinical psychology training is associated with a high prevalence of stress, at least in the research conducted that has used UK and Australian samples. These differences could make the results difficult to generalise to other contexts. The sample used may present some particular characteristics. For instance, the participants were postgraduate psychologists enrolled in a Master's degree programme in clinical and health psychology. They matriculated into the postgraduate courses after a highly selective process, where lectures are delivered in a small group format and students are in a context where integral and caring education is promoted.

Throughout the MSC training sessions that were conducted in the current study, no adverse emotional effects were detected among the participants. Some participants, however, were not fully committed to the programme. Further exploration of the factors involved in low adherence would have been interesting.

Concerning the instruments that were used to measure the study's variables, this study relies on self-report measures. Although all the scales used in this study are widely used in psychological research and presented good reliability, the risk of potential bias (e.g., social desirability, errors in recalling, etc.) may affect these types of measures. In particular, a single-item measure was used to evaluate the participants' adherence to the MSC programme, which may be a cause of concern. Despite potential reliability issues and the subjectivity inherent to this measure, the extent to which the participants self-assessed their compliance with the MSC protocol turned out to be a useful differentiator between the groups. However, a more sophisticated measure of adherence is advisable in future research.

New hypotheses may be derived from the present study. Clinical psychologists who have previously become familiar with the applications, outcomes, and limitations of self-compassion and mindfulness-based interventions will likely be more confident in using a compassionate approach in their professional practice. Moreover, they may become more skilled in understanding their clients and their own patterns of responding (Rimes & Wingrove, 2011). Testing these hypotheses is beyond the scope of the present study. However, it could be a compelling line of research. It is worth mentioning that such hypotheses are aligned with the PP model. According to Bennett-Levy and Finlay-Jones (2018), PP will secondarily impact conceptual and technical skills to the extent that the bridge from the "personal self" to the "therapist self" is crossed, and therapists will reflect on the implications of PP in professional practice. However, a study that analyses the links among PP, therapist skills, and client outcomes has yet to be conducted (Bennett-Levy & Finlay-Jones, 2018).

4.2 | Practical implications for postgraduate training

Some recommendations concerning postgraduate training in clinical and health psychology can be derived from the current study. Beyond the identified positive emotional outcomes, the MSC programme may have intrinsic educational value in the context of clinical and health psychology courses. Mindfulness and self-compassion are important skills for clinicians to develop for themselves, with potential beneficial impacts on their work with clients. Delivering programmes that aim to enhance self-compassionate attitudes in psychologists may be a promising method to train their professional competencies during postgraduate courses. In addition, including assessments of the self-compassion training's effectiveness to produce the desired outcomes (e.g., protection against professional burnout and compassion fatigue, increases in well-being, enhanced emotional skills, etc.) is advisable. The evaluation of the programmes' effectiveness would represent progress in identifying the approaches that are best suited for teaching self-care (Pakenham, 2017).

For some participants, self-compassion and compassion-focused trainings may be an emotionally challenging experience (Boellinghaus et al., 2014). For instance, these trainings may trigger physiological threat responses, feelings of grief, and negative beliefs about compassion in some individuals. MSC trainers have sometimes discussed the "backdraft" effect, a term that refers to emotional

disturbances that may be triggered during self-compassion interventions in which the participants become aware of hidden wounds and fears. Backdraft is considered to be part of the emotional process of emotional transformation in the MSC programme (Germer & Neff, 2013). Therefore, teachers are encouraged to carefully monitor the impact of self-compassion trainings due to their potential emotional impact on trainees (Boellinghaus et al., 2013).

Our findings are aligned with previous research that has recently demonstrated the usefulness of compassion-focused training for health-care professionals (Beaumont & Hollins-Martin, 2016; Beaumont, Rayner, Durkin, & Bowling, 2017; Bell, Dixon, & Kolts, 2017; Bibeau et al., 2016; Lown, 2016). The Mindful Self-Compassion programme, of course, does not exhaust all the available options to train clinical and health psychologists' competencies. For instance, Compassion-Focused Therapy (Gilbert, 2009, 2010, 2014) may also be a valuable alternative. Recently, self-experiential methods to train compassion-focused therapists have been proposed (Kolts, Bell, Bennett-Levy, & Irons, 2018), which may also have beneficial effects for the therapists' personal and professional development. In addition, this approach may provide them with focused skills for working with clients. For example, compassion satisfaction, that is, positive feelings derived from helping other people, has been found to contribute to building a satisfactory working alliance between therapists and clients (Carmel & Friedlander, 2009). Therefore, the use of alternative compassion-based approaches for training clinical and health psychologists' competencies may also be recommended.


5 | CONCLUSION

The Mindful Self-Compassion programme may offer a useful approach to training clinical and health psychologists in the skills needed to cope with the emotional demands at work. In addition, gaining first-hand experience with MSC could be a method to incorporate new techniques into the psychologists' toolbox. MSC therefore constitutes a promising practice to be considered for inclusion in formative programmes for clinical and health psychologists.

CONFLICT OF INTEREST

None.

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How to cite this article: Yela JR, Gómez-Martínez M^a Ángeles, Crego A, Jiménez L. Effects of the Mindful Self-Compassion programme on clinical and health psychology trainees' well-being: A pilot study. *Clin Psychol.* 2019;1–14. <https://doi.org/10.1111/cp.12204>